IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 21, 2012

Amy Rackham, Administrator
Gables Of Ammon Management, Inc
1405 Curlew Drive
Ammon, ID 83406

License #: RC-1013

Dear Ms. Rackham:

On September 26, 2012, a Complaint Investigation was conducted at Gables Of Ammon Management, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Donna Henscheid

Donna Henscheid, LSW
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program

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October 9, 2012

CERTIFIED MAIL #: 7007 3020 0001 4050 7916

Mitch Mansanarez, Owner
Gables of Ammon Management, Inc.
1405 Curlew Drive
Ammon, ID 83406

Dear Mr. Mansanarez:

Based on the Complaint Investigation survey conducted by our Licensing and Certification staff at Gables of Ammon Management, Inc. from **September 24 - 26, 2012,** we have determined that the facility failed to protect residents from abuse and inadequate care.

These core issue deficiencies substantially limit the capacity of Gables of Ammon Management, Inc. to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiencies are described on the enclosed Statement of Deficiencies. As a result of the survey findings, the Department is issuing the facility a provisional license, effective October 9, 2012 through April 9, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

> ***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***
> *A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions of the provisional license are as follows:

1. **A registered nurse consultant, with experience working for a residential care assisted living facility in Idaho as a registered nurse, will be obtained and paid for by the facility, and approved by the Department. This registered nurse consultant must have an Idaho nursing license, and may not also be employed by the facility or company that operates the facility. The registered nurse consultant must be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than October 15, 2012.**

2. **The Department approved consultant will submit a weekly written report to the Department commencing on October 19, 2012, and every Friday thereafter. The reports will address progress on correcting the core deficiencies described on the Statement of Deficiencies and Non-Core Issues Punch List.**

3. **The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.**

4. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**

5. **The facility will retain a minimum of one, full-time nurse to provide nursing oversight at the facility. The nurse will work a minimum of forty (40) hours per week. This nurse must be one individual, as opposed to an agency that provides rotating nursing services.**

6. **When the facility nurse is not available in the building, the facility will maintain at all times, an on-call, licensed nurse available to provide consultation to facility staff and to respond to the facility within one hour to respond to resident changes of condition, conduct assessments and make determinations regarding further care or emergency services.**

7. **The facility will retain a full-time (40 hours per week), residential care administrator, who has both a full residential care administrator's license in Idaho and at least one year previous experience serving as a residential care administrator for an Idaho facility.**

8. **When the consultant, the administrator and the facility nurse agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Debby Ransom, R.N., R.H.I.T.
Bureau Chief, Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of these deficiencies must be achieved by **November 13, 2012. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?

- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?

- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **October 22, 2012,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 22, 2012**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 22, 2012,** your request will not be granted. Your IDR request must me made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 26, 2012**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Gables of Ammon Management, Inc.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

DH/JS

Enclosure

cc: Medicaid Notification Group
Steve Millward, Licensing & Certification

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R1013	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF AMMON MANAGEMENT, INC	1405 CURLEW DRIVE AMMON, ID 83406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1	R 008	RULE 008	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility did not coordinate care for 2 of 9 sampled residents (Residents #1 and #6) who had outside services. Further, the facility retained 2 of 3 sampled residents (Residents #1 and #3) who had wounds that progressed beyond what the facility was licensed to provide care for. Lastly, the facility did not ensure their emergency policy was implemented for 2 of 3 sampled residents (Residents #1, and #4) who had multiple falls and changes in conditions. The findings include: I. COORDINATION OF CARE IDAPA 16.03.22.011.08 defines inadequate care as "When the facility fails to provide...coordination of outside services..." 1. Resident #6 was a 58 year old female who was admitted to the facility on 6/1/12 with diagnoses of diabetes and right-sided paralysis. A caregiver progress note, dated 7/23/12, documented Resident #6 reported a "blister" on her left heel. The progress note also documented, "RN notification form filled out. Will Continue to monitor." A fax to Resident #6's physician, dated 7/23/12, documented, "Pt has developed a blister to her L	R 008	16.03.22.520 Protect Residents from Inadequate Care I. Coordination of Care Resolution: 1. Resident #6- is on home health with Teton Home Health and Hospice. She is currently doing wound care at EIRMC. Recent wound notes show that the diabetic ulcer is not healing biweekly. We issued a 30 day notice to leave the facility on October 19, 2012. Resident #1- has passed away. 2. An audit was conducted to discover the outside services currently providing cares in the building. The list of residents was updated to include their Outside Service of choice. 3. On October 16, 2012, The Gables of Ammon Senior Living conducted a meeting with the Outside Service Agencies who have contracts within the building. The Facility Nurse, Heather Schofield discussed the communication required to maintain the resident cares. The following items were discussed: A. All agencies were advised that care notes would be delivered weekly.	

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R 008	Continued From page 2 medial heel. I have scheduled Pt to see wound care at [Wound Care Clinic's name] on 7/25/12 for wound care." The fax was signed by the previous facility RN. On 9/26/12 at 9:00 AM, Resident #6's record was reviewed and did not contain any further documentation regarding the wound on her heel. On 9/25/12 at 3:00 PM, when the administrator was asked why there was no further documentation regarding Resident #6's wound, the administrator stated Resident #6 went to the wound clinic on one occasion and "everything was okay." On 9/26/12 at 8:20 AM, the current facility RN stated the first day she was notified of Resident #6's wound was on 9/24/12. She confirmed she did not know the current status of the wound. On 9/26/12 at 9:45 AM, the Administrator's Assistant stated she requested records from the wound clinic regarding Resident #6's wound, per surveyors request. She further stated, when she called to request the records, she was informed that Resident #6 was receiving weekly wound treatments at the wound clinic. The wound clinic care notes were received by the facility on 9/26/12 at 9:40 AM per surveyor's request. The notes, dated 9/19/12, documented Resident #6, had 3 wounds present on her left foot. One wound was on the heel, one was on the side of her foot, and the other was on her toe. On 9/26/12, at 10:55 AM, a caregiver stated she had just found out "today" about Resident #6's wounds, when toileting her. She had not been instructed on how to care for them, what to	R 008	B. All visit notes left at the facility would be specific and detailed. There would be no discrepancy between those and the weekly service notes. C. All verbal communication would be directed to the RCC, Angie Parks or the Facility RN, Heather Schofield, prior to their exit from visit. D. All residents leaving the facility for cares, such as doctor visits, therapies, or other treatments would require documentation of those cares. E. The Facility RN and Administrator would review all NSA's and update and coordinate care with Outside Services. 4. On October 19, 2012, The Gables of Ammon Senior Living issued a letter to the Outside Service Agencies. The letter documented the October 16, 2012 meeting and the requirements for communication of cares. 5. The Administrator and RN are currently reviewing the NSA agreements and updating as necessary to include extended services. The RN Consultant will complete random audits of residents with outside services during weekly visits until survey issues have been cleared. 6. Date of Compliance will be November 13, 2012.	

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R 008	Continued From page 7 II. RETENTION 1. Resident #1 was a 79 year old female resident who was admitted to the facility on 7/10/12 with a diagnosis of end stage renal failure. IDAPA 16.03.22.152.05 documents that residents with "open, draining wounds for which the drainage cannot be contained," and open wounds that are not "improving bi-weekly" cannot be retained. During a tour of the facility, on 9/24/12 at 2:15 PM, Resident #1 was observed sitting in her room on a fabric recliner with her legs elevated. Upon entering the resident's room a musty odor was noted. Wounds without dressings were observed on both of the resident's legs. The resident's left leg was observed to have 3 open wounds that were approximately 0.25 inches in diameter. One wound was observed to have fluid in it, which "bubbled-up" and then drained down the resident's leg into her recliner. The resident's right leg was observed to have 2 open wounds. One wound was located on her shin and was approximately 2.5 inches in width and 4 inches in length. The bed of the wound was covered by a white, foamy substance (slough) and the perimeter was red and swollen. The second wound was located on the back of the calf and was approximately 1.5 inches in diameter. The wound, which was in direct contact with the cloth recliner, was also observed to have slough. Drainage from the second wound was observed to soak into the recliner. The foot rest of the recliner was observed to have dried stained areas from prior drainage of fluids. Additionally, while in the resident's room a fly was observed to crawl across the open wounds.	R 008	Rule # 16.03.22.152.05 Policies of Acceptable Admissions II. Retention of Residents Resolution: 1. Resident # 1 has passed away. Resident #3 wounds are completely healed. 2. An audit has been conducted to identify any skin issues and wounds within the facility. These wounds are being tracked. We have requested wound care documentation as well as notified Outside Service Agencies of new communication and clinical note policies. This audit identified non-healing wound with Resident #6 and a 30-day discharge notice was given on October 19, 2012.	

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R 008	Continued From page 8 On 9/25/12 the resident's record was reviewed. The record did not contain documentation from the facility's nurse regarding wounds. The record did document the resident was on hospice services. Caregiver progress notes, contained in the record documented the following: *8/21/12 - "Resident's legs are still swollen and have a rash. Her feet are leaking water and she has blisters on her legs." *8/22/12 - "The base of her leg/foot are leaking liquid and has some blisters." *8/24/12 - "...has open sores on legs. Hospice nurse said they would not wrap them, to just leave them be." *9/8/12 - "...legs are leaking body fluid..." *9/13/12 - "Her legs are still red and leaking." *9/17/12 - "Legs are still oozing and sores all over." *9/19/12 - "Legs are still weaping [sic] & red w/sores." The record contained "Outside Service Provider Forms" which documented the following: *8/6/12 - "lower legs are becoming hot and red" *8/13/12 - "severe edema, red swollen legs" *8/17/12 - "weeping from her legs has increased" *8/24/12 - "...expressed her wishes to not treat the sores on her legs in any way. Please do not wrap" *8/27/12 - "more sores on legs" *8/31/12 - "sores are worse on her legs" *9/19/12 - "lower legs are dry, red and ulcerated" The facility nurse signed and dated each of the "Outside Service Provider Forms" in the record. There was no documentation the facility nurse	R 008	3. The Administrative Policy and Idaho State Rules for Assisted Living were reviewed with the Administrative team on 10/10/12 by the RN Consultant. All residents with would will be assessed weekly by the Facility RN. The Administrator will notify resident, family and MD if resident's condition warrants discharge from the facility due to conditions outside the facility's licensed ability to provide care. Arrangements will be made to seek appropriate temporary or long term placement. The daily Stand-Up meeting agenda was changed to discuss skin issues, falls, med errors, etc. 4. Administrator and Facility RN will review all residents on a weekly basis for one month, then monthly to ensure all residents meet the acceptable retention. 5. Date of compliance is November 13, 2012.	

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R 008	Continued From page 13 *A "Home Health Certification And Plan Of Care," dated 5/19/12, documented Resident #3 was diagnosed with a Stage IV pressure ulcer. *A home health nursing assessment, dated 5/19/12, documented the resident had a Stage IV pressure ulcer to the coccyx which measured 10 cm x 3.5 cm. The facility RN documented on 6/23/12, "Pt has a wound to gluteal folds with redness and with some slough..." The RN did not document the stage of the wound or evaluate if the wound was appropriate for assisted living. However, the slough observed indicated the pressure ulcer was greater than a Stage II. On 9/25/12 at 9:50 AM, Resident #3's home health RN, stated Resident #3's wound was "extensively large when we took over." She stated two open areas were present. One was a Stage IV. The facility retained Resident #1 with open, draining wounds for which the drainage was not contained. They also did not determine if Resident #1's wounds were improving bi-weekly. Additionally, they retained Resident #3 who had a Stage IV pressure ulcer. III. EMERGENCY INTERVENTION The facility's "Emergency Preparedness and Response Policy" documented "Any situation that arises that affects the health, condition, or mental status of a resident, or arises out of a resident's actions will immediately be communicated to the facility RN - by telephone if not available onsite. The RN will instruct caregivers at that time what further actions may need to be taken."	R 008	Rule # 16.03.22.520 Protect Residents from Inadequate Care III. Emergency Intervention Resolution:	

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R 008	Continued From page 14 IDAPA 16.03.22.520 - The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. IDAPA 16.03.22.011.08 - Inadequate care . When the facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for.....supervision, first aid...emergency intervention... 1. Resident #4 was a 72 year old female, admitted to the facility on 11/1/11 with diagnoses including terminal cancer and confusion. Incident reports documented the following: *3/3/12 - the resident fell at 6:50 AM in the front lobby. It further documented the hospice agency was notified via fax on 3/7/12. On 3/7/12, four (4) days after the incident occurred, the facility RN documented "no injuries were found." *3/11/12 - the resident slid out of bed at 9:24 AM and had "no marking" or pain. It further documented that hospice was notified via fax. On 3/15/12, four (4) days after the fall, the facility RN documented the resident had medication changes and would continue to monitor. *3/12/12 - Resident #4 was found on the floor at 7:58 AM and had "no apparent injuries." The resident stated she hit her head and hospice was notified. On 3/15/12, three (3) days after the fall, the facility RN documented the resident had recent medication changes and increased confusion, weakness and sleeping. There was no documentation the resident's head was checked for injury.	R 008	1. Resident #1 has passed away. Resident #4 has passed away. 2. We have recently reviewed the incident reports for October. We have found areas that need corrected such as investigation and who needs notified. Emergency interventions were discussed at the staff meeting held on October 15, 2012. Staff was told to call 911 or the facility nurse with every incident depending on its severity. They were instructed that 911 calls would be for emergent change of conditions such as stroke, heart attack, chest pain, fall with head injury, etc. Minor incidents such as skin tears, bumps, falls without injury etc., would be called in to the Facility RN and the Home Health/Hospice nurse if applicable. Family will be notified by the manager on-call or nurse only. When necessary, the Facility RN or Home Health/Hospice nurse would come into the facility to evaluate and treat the resident. The RCC, RCC Assistant, and Facility RN were taught how to appropriately investigate the incidents and how to document the investigation.	

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R 008	Continued From page 15 *3/13/12 - the resident was found at 9:30 PM with a skin tear to her right cheek. On 3/15/12, two (2) days after the incident occurred, the facility RN documented the resident had medication changes due to increased weakness and lethargy. There was no documentation the skin tear was assessed. *3/14/12 - Resident #4 was found at 8:00 AM on the floor between her bed and night stand. The resident had a skin tear on her right arm, "marks" on her back, redness on her shoulder and a bruise on the right hip. On 3/15/12, the day after the fall, the facility RN documented the hospice nurse was there to dress the resident's wounds. *3/24/12 - the resident fell at 6:47 AM onto her right side while standing in the hallway. On 3/26/12, two (2) days after the fall the RN documented the resident had "no evident injuries at this time." *4/21/12 - the resident fell in the lobby at 10:30 AM. It further documented a message was left with the hospice agency at 1:30 PM, two hours after the fall. *4/30/12 - at 8:49 PM, Resident #4 was found sitting on the floor with her back against the couch. It further documented that hospice and the son were notified. *5/7/12 - the resident fell at 4:30 PM in another resident's room. It further documented the family was notified. On 5/8/12, the facility RN documented, on the incident report, the resident denied pain and seemed "emotional..." *5/9/12 - Resident #4 fell backwards at 7:30 AM	R 008	3. All incidents will be reviewed at Stand Up meetings every morning Monday thru Friday. The Facility RN will assess the resident after the incident. The Administrator and Facility RN will review all incidents and document their investigations and actions taken as well. 4. All incidents will be documented on the Bluestep program. This will be easier to track interventions and investigations. This program will be completely running on November 1, 2012. Paper incident reports will be completed until that date. 5. Date of Compliance will be November 13, 2012.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 20 #1 and #6 who had outside services. Further, the facility retained Residents #1 and #3 who had wounds that progressed beyond what the facility was licensed to provide. Lastly, the facility did not ensure their emergency policy was implemented for Residents #1, and #4 who had multiple falls and changes in condition. These failures resulted in inadequate care.	R 008		
R 009	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by: Based on interview and record review it was determined the facility did not protect 1 of 9 sampled residents (Resident #8 from neglect) when they failed to ensure the facility's licensed professional nurse assessed the resident when she had changes in condition. Further, the facility did not protect Resident #8 from neglect when they did not implement interventions to prevent the reoccurrence of her falls. IDAPA 16.03.22.011.24 - defines neglect as the "Failure to provide food, clothing, shelter, or medical care necessary to sustain the life and health of a resident." IDAPA 16.03.22.525 - documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect." IDAPA 16.03.22.305.03 documents the facility RN must, "...Conduct a nursing assessment of the health status by identifying...any changes	R 009	R009 Rule # 16.03.22.525 Protect Residents from Neglect Resolution: 1. Resident #1 has passed away. Resident #8 has passed away. 2. Staff was educated on October 15 & 19, 2012 on documenting change of conditions. They were instructed to document fact, specific and detailed information, as well as whom to notify if the change is significant. Instructions about time being of the essence with regard to emergent incidents or changes were also discussed. Protocol for contacting 911 and the nurse were reviewed.	

PRINTED: 10/05/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R1013	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF AMMON MANAGEMENT, INC	1405 CURLEW DRIVE AMMON, ID 83406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 009	Continued From page 21 In...physical health status." Resident #8 was a 76 year old female admitted to the facility on 2/27/12 with diagnoses of Parkinson's disease and dementia. An NSA, dated 2/27/12, documented staff needed to monitor the resident for falls. The "Provider Instructions" section documented the resident had "no falls or history (of falls) at this time." Unlicensed caregiver progress notes documented the following: *3/11/12 - the resident fell against a car and slid down onto the pavement *4/3/12 - the resident fell, hit the back of her head and received 5 staples to her head *4/6/12 - the resident was found on the bathroom floor. The resident stated she "bumped her head. No redness or bleeding from her staples..." On 4/10/11, four (4) days after falling a second time and hitting her head, the resident was assessed by the facility RN. *4/29/12 - resident had "no apparent injury" from an additional two falls. On 4/30/12, two (2) days after having two falls, the facility RN documented the resident "had some ear pain. *5/14/12 - the resident "had a fall today" and was found sitting on the floor by the housekeeper. The resident complained of "minimal upper left leg pain and was given a pain pill per RCC" *5/22/12 - the resident had fallen in the hallway, but had "no apparent" injuries.	R 009	3. The Facility RN will be notified of change of conditions through Alert charting on Bluestep and verbally. The Alert charting will be reviewed daily by the RCC/RCC Assistant and the Facility RN. The Facility RN will then complete an assessment of the resident, including fall risk. The Facility RN, RCC, RCC Assistant, and Administrator will implement fall precautions. 4. The Facility RN has conducted assessments for those residents with previous falls. The facility has purchased pressure pad alarms with monitors, which will be located at the nurse stations/med carts in each hall. It has also purchased pool noodles/bed pillows for residents who roll out of bed. The facility will recommend new habilitation equipment as needed such as wheelchairs, walkers, gait belts, etc. It will also contact the M.D. and request needed physical therapies. 5. Significant changes will be reviewed at Stand Up every morning Monday-Friday. Families will be contacted by RCC, RCC Assistant or Facility RN with significant changes, when fall precautions are recommended, and if precautions are ineffective. 6. Date of Compliance will be November 13, 2012.	

Amy Rabb Administrator 10/22/12

Reset Form | Print Form

IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Gables of Ammon	1405 Curlew Drive	208-542-3400
Administrator	**City**	**Zip Code**
Amy Johnson	Ammon	83406
Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Complaint	09/26/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	215	The facility did not have a licensed administrator for less than 30 days.		11/21/12 DH
2	300.01	A caregiver assisted with medications prior to being delegated by the RN.		11/21/12 DH
3	300.02	The facility RN was not notified when Resident #6's blood glucose level was above 500 and she was experiencing vomiting. Additionally,		11/21/12 DH
		on one occasion, Resident #6 received the wrong dose of insulin. The facility nurse did not ensure Resident #10's coumadin order was		
		implemented as ordered. Residents #1, 4 and 8 were not assessed by the facility nurse after falls.		
4	305.02	The facility did not ensure medications were available as ordered.		11/21/12 DH
5	305.06	Resident #6 was not assessed to determine if she was safe to interpret sliding scale levels and self-inject insulin.		11/21/12 DH
6	310.01.d	Unlicensed staff were determining Resident #6's insulin dosages.		11/21/12 DH
7	320.01	Resident #1 did not have an NSA. Resident #3, 4, and 6's NSAs were not updated to reflect their current care needs. For example skin break		11/21/12 DH
		down issues, insulin management, and description of specific services outside agencies were providing. **Repeat Punch, cited on 3/13/12**		
8	600.05	The administrator did not ensure orientation training was adequate so caregivers had knowledge of residents' care needs.		11/21/12 DH
9	711.08.c	The facility did not document the steps they took when medications were unavailable.		11/21/12 DH
10	711.11	The facility did not document the reasons why medications were not given.		11/21/12 DH
11	350.02	The administrator did not conduct an investigation into incidents and accidents.		11/21/12 DH
12	152.05.b.iii	Resident #1 had bedrails attached to her bed.		11/21/12 DH

Response Required Date	Signature of Facility Representative	Date Signed
10/26/12	Amy J Johnson	9/26/12

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 9, 2012

Mitch Mansanarez, Owner
Gables of Ammon Management, Inc.
1405 Curlew Drive
Ammon, ID 83406

Dear Mr. Mansanarez:

An unannounced, on-site complaint investigation survey was conducted at Gables of Ammon Management, Inc. from September 24-26, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005673

Allegation #1: The facility did not have enough staff on duty to provide assistance to the residents.

Findings #1: Findings #1: On 9/24/12, from 2:00 PM to 4:00 PM, a tour of the facility was conducted and residents were interviewed. Twenty-two residents stated they felt there were enough staff to meet their needs. Two residents and one family member, stated the facility could use more staff during emergencies, but they believed residents' needs were still being met.

Between 9/24/12 and 9/26/12, observations were conducted. Staff were observed readily available in each wing of the facility. Residents were observed well-groomed and dressed appropriately. The facility was observed to be clean and well maintained. Residents were observed being assisted to eat during meal times; staff were observed providing assistance with cares and responding to call lights.

During the survey, 6 caregivers were interviewed. They stated they felt there was sufficient staff to meet the needs of the residents. They stated a caregiver and medication aide were assigned to each wing and they teamed up when providing cares to residents. They did express frustration with "call ins," but stated, they had been able to meet the needs of the residents during those strained times.

On 9/26/12 at 3:10 PM, the administrator and resident care coordinator, stated when they began employment, they restructured the staffing patterns. They stated they

scheduled aides on each wing to hold them more accountable and to provide better continuation of care for residents. They acknowledged that there were frequent "call ins," but did not believe this caused residents' needs to go unmet.

July 2012 through September 2012 staff schedules documented 6 caregivers were scheduled for the day shift, 4 for the evening shift, and 2 for the night shift. The complaint log documented there had been one complaint received regarding staff on weekends; however, the facility staffing schedule did not document a different staffing pattern for the weekend.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: Food was served cold.

Findings #2: Substantiated. However, the facility was not cited as they acted appropriately by implementing interventions to correct the situation. During the survey, residents acknowledged it was a problem at one time, but stated currently they were satisfied with the temperature the food was served at. The cook acknowledged complaints were received from residents regarding food being served cold; to resolve the situation, they began heating up the plates, and changing their process for delivering meals to ensure meals were delivered when hot. Additionally, the administrator stated, after multiple complaints were received, additional servers were hired to streamline the serving process. During the survey, meals were observed being delivered to residents in a prompt manner, while the food was hot.

Allegation #3: Call lights were not answered in a timely manner.

Findings #3: On 9/24/12, from 2:00 PM to 4:00 PM, a tour of the facility was conducted and residents were interviewed. Twenty-two residents stated staff responded to their call lights in a timely manner. Three residents stated, on occasion, they have had to wait 20 or more minutes for staff to respond. During this time, a resident was observed using her call light. Staff responded to her request in less than 2 minutes.

Between 9/24/12 and 9/26/12, observations were conducted. Staff were observed readily available in each wing of the facility. It was not observed that call lights went unanswered for an extended time.

On 9/26/12 at 3:00 P M, the administrator and resident care coordinator stated they monitored the length of time that it took for staff to respond to call lights. If a light was observed not answered in a timely manner, they would answer the light and investigate the situation.

On 9/25/12, the complaint log and resident council notes were reviewed. There were no documented complaints regarding call lights not being answered in a timely manner.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/tfp

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program

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October 9, 2012

Mitch Mansanarez, Owner
Gables of Ammon Management, Inc.
1405 Curlew Drive
Ammon, ID 83406

Dear Mr. Mansanarez:

An unannounced, on-site complaint investigation survey was conducted at Gables of Ammon Management, Inc. from September 24-26, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005684

Allegation #1: Call lights were not answered in a timely manner.

Findings #1: On 9/24/12, from 2:00 PM to 4:00 PM, a tour of the facility was conducted and residents were interviewed. Twenty-two residents stated staff responded to their call lights in a timely manner. Three residents stated, on occasion, they had to wait 20 or more minutes for staff to respond. During this time, a resident was observed using her call light. Staff responded to her request in less than 2 minutes.

Between 9/24/12 and 9/26/12, observations were conducted. Staff were observed readily available in each wing of the facility. Call lights were observed to be answered in a timely manner.

On 9/26/12 at 3:00 PM, the administrator and resident care coordinator stated they monitored the length of time that it took for staff to respond to call lights. If a light was observed not answered in a timely manner, they would answer the light and investigate the situation.

On 9/25/12, the complaint log and resident council notes were reviewed. There were no documented complaints regarding call lights not being answered in a timely manner.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: There was not sufficient staff to meet the needs of the residents.

Findings #2: However, the facility was not cited as they acted appropriately by On 9/24/12, from 2:00 PM to 4:00 PM, a tour of the facility was conducted and residents were interviewed. Twenty-two

residents stated they felt there were enough staff to meet their needs. Two residents and one family member, stated the facility could use more staff during emergencies, but they believed residents' needs were still being met.

Between 9/24/12 and 9/26/12, observations were conducted. Staff were observed readily available in each wing of the facility. Residents were observed well-groomed and dressed appropriately. The facility was observed to be clean and well maintained. Residents were observed being assisted to eat during meal times; staff were observed providing assistance with cares and responding to call lights.

During the survey, 6 caregivers were interviewed. They stated they felt there was sufficient staff to meet the needs of the residents. They stated a caregiver and medication aide were assigned to each wing and they teamed up when providing cares to residents. They did express frustration with "call ins," but stated, they had been able to meet the needs of the residents during those strained times.

On 9/26/12 at 3:10 PM, the administrator and resident care coordinator, stated when they began employment, they restructured the staffing patterns. They stated they scheduled aides on each wing to hold them more accountable and to provide better continuation of care for the residents. They acknowledged that there were frequent "call ins," but did not believe this caused residents' needs to go unmet.

July 2012 through September 2012 staff schedules documented 6 caregivers were scheduled for the day shift, 4 for the evening shift, and 2 for the night shift. The complaint log documented there had been one complaint received regarding staff on weekends; however, the facility staffing schedule did not document a different staffing pattern for the weekend.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: Newly hired caregivers did not receive adequate training.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.6000.05 for not ensuring orientation training was adequate so that caregivers had knowledge of residents' care needs. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility RN did not provide delegation to an identified medication aide prior to the aide providing assistance with medications.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.01, for the facility nurse not providing delegation to a caregiver who assisted with medications. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not ensure medications were assisted with as ordered.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not assisting with medications as ordered. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: When residents ran out of medications, the facility did not implement interventions to obtain medications in a timely manner.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02, for not ensuring medications were available as ordered and 711.08.c for the facility not documenting the steps they took when medications were unavailable. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: An identified resident was not assisted with a PRN (as-needed) laxative when she requested it.

Findings #7: On 9/25/12, the identified resident's record was reviewed. The resident's August 2012 medication assistance record (MAR) documented the resident was assisted with a laxative "per her request" on 8/6/12 and 8/26/12. August 2012 "ADL" (activities of daily living) sheets, documented the resident had regular bowel movements. Hospice RN assessments documented the resident had normal bowel movements. There was no indications in the record, that the resident required a laxative, beyond the two days she requested it.

On 9/25/12 at 1:27 PM, the identified resident was determined not to be interviewable. At 1:30 PM, a caregiver was observed assisting the resident out of bed to the restroom. During this time, the caregiver stated the resident had experienced a decline and could not always request PRNs; however, to her knowledge, she had received PRNs when requested in the past.

On 9/25/12, between 2:00 PM and 4:00 PM, a medication aide and another caregiver were interviewed separately. They stated they did not recall a time when the identified resident requested a PRN laxative that she did not receive.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation # 8: Medications kept in the nurses' office were not locked up.

Findings #8: Substantiated. However, the facility was not cited as they acted appropriately by correcting the deficient practice prior to the date of the survey.

Allegation #9: There was no current administrator to oversee day to day operations.

Findings #9: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215 for not having a licensed administrator at all times. The facility was required to submit evidence of resolution within 30 days.

Allegation #10: The facility did not coordinate care to ensure residents' needs were met.

Findings #10: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failure to coordinate care. The facility was required to submit a plan of correction.

Core issue deficiencies were identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **September 26, 2012.** The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/tfp

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program

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October 9, 2012

Mitch Mansanarez, Owner
Gables of Ammon Management, Inc.
1405 Curlew Drive
Ammon, ID 83406

Dear Mr. Mansanarez:

An unannounced, on-site complaint investigation survey was conducted at Gables of Ammon Management, Inc. from September 24-26, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005702

Allegation #1: The facility staff did not respond appropriately to an emergency which delayed treatment.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for delaying emergency interventions. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not coordinate nursing services to ensure residents were assessed for changes of conditions.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not ensuring residents were evaluated by the nurse for changes of condition. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not investigate residents' falls and put interventions into place to prevent residents from falling.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not conducting an investigation into all accidents and incidents. The facility was required to submit evidence of resolution within 30 days.

Core issue deficiencies were identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **September 26, 2012**. The completed punch list form

and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/tfp

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program